

"Hashem is King his son is prince"

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Robert Lee Murray known
as Leviticus BARNET Lucifer

Write the full name of each plaintiff.

No. 21-CV-06718 (JL)
(To be filled out by Clerk's Office)

amended
COMPLAINT
(Prisoner)

-against-

City of New York
Dept For John Doe C.O's 7
1 Female Jane Doe Capt.

Do you want a jury trial?
☐ Yes ☒ No

Trial By Judge
DEMANDED

Write the full name of each defendant. If you cannot fit the names of all of the defendants in the space provided, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed above must be identical to those contained in Section IV.

NOTICE

The public can access electronic court files. For privacy and security reasons, papers filed with the court should therefore *not* contain: an individual's full social security number or full birth date; the full name of a person known to be a minor; or a complete financial account number. A filing may include *only*: the last four digits of a social security number; the year of an individual's birth; a minor's initials; and the last four digits of a financial account number. See Federal Rule of Civil Procedure 5.2.

RECEIVED
CLERK OF COURT
JUL 19 2023

I. LEGAL BASIS FOR CLAIM

State below the federal legal basis for your claim, if known. This form is designed primarily for prisoners challenging the constitutionality of their conditions of confinement; those claims are often brought under 42 U.S.C. § 1983 (against state, county, or municipal defendants) or in a "Bivens" action (against federal defendants).

☒ Violation of my federal constitutional rights

☐ Other: _____

II. PLAINTIFF INFORMATION

Each plaintiff must provide the following information. Attach additional pages if necessary.

Robert Lee Murray
First Name Middle Initial Last Name

Leviticus Buford Lucifer
State any other names (or different forms of your name) you have ever used, including any name you have used in previously filing a lawsuit.

950-22-00004
Prisoner ID # (if you have previously been in another agency's custody, please specify each agency and the ID number (such as your DIN or NYSID) under which you were held)

18-18 Hazen St East Elmhurst NY 11370
Current Place of Detention

AMKC 18-18 Hazen St
Institutional Address

Elmhurst NY 11370
County, City State Zip Code

III. PRISONER STATUS

Indicate below whether you are a prisoner or other confined person:

- ☒ Pretrial detainee
☐ Civilly committed detainee
☐ Immigration detainee
☐ Convicted and sentenced prisoner
☐ Other: _____

IV. DEFENDANT INFORMATION

To the best of your ability, provide the following information for each defendant. If the correct information is not provided, it could delay or prevent service of the complaint on the defendant. Make sure that the defendants listed below are identical to those listed in the caption. Attach additional pages as necessary.

Defendant 1: Dept Foo
 First Name Last Name Shield #
Dept.
 Current Job Title (or other identifying information)
18-18 HAZEN ST
 Current Work Address
Elmhurst NY 11370
 County, City State Zip Code

Defendant 2: 7 John Doe Officer
 First Name Last Name Shield #
18-18 HAZEN ST C.O.
 Current Job Title (or other identifying information)
18-18 HAZEN ST
 Current Work Address
East Elmhurst NY 11370
 County, City State Zip Code

Defendant 3: 1 Jane Doe Capt
 First Name Last Name Shield #
Capt's
 Current Job Title (or other identifying information)
18-18 HAZEN ST
 Current Work Address
Elmhurst NY 11370
 County, City State Zip Code

Defendant 4:
 First Name Last Name Shield #
 Current Job Title (or other identifying information)
 Current Work Address
 County, City State Zip Code

V. STATEMENT OF CLAIM

Place(s) of occurrence: AMKC receiving Room area

Date(s) of occurrence: NOV 14, 2020 TO NOV 15, 2020 TO NOV 16, 2020 in receiving Room area

FACTS:

State here briefly the FACTS that support your case. Describe what happened, how you were harmed, and how each defendant was personally involved in the alleged wrongful actions. Attach additional pages as necessary.

I am STATEing all The FACTS OF The incident in a written STATEMENT as The court instructed me to DO I Sending a \$160.50 attached To This Document with medical release forms I need To court To understand I Fell UNconscious at The Time of The sexual assault and at That Time I lost memories my mind went Blank at The Time of The sexual assault I also call prisoners' Rights project and They requested That The video of That area Be preserved from when I was in The Receiving Room area and when I left. prea was contacted They Told me That There was an investigation and They would look at The cameras I contacted a Lawyer Name MATTHEW B. WALLER he contacted a NOther Lawyer Name Soil They order my medical record From Rikers Island There records indicated That The incident

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Never happened I got release and I went to Bellevue Hospital and the records was there so Rikers Island made fake medical records and they have a copy of those records if they have done this to me how many ~~for~~ people have they done this to and got away with it and how many of the fake records has they filed with the court and got cases dismissed

The rape happen on Nov 15, 2020 any time of 4:00am and 9:00am in the morning

I got to the Rikers Island Facility on Nov 14, 2020 I sleep so it had to be the morning of Nov 15, 2020

ON NOV 14, 2020 I was Lock up on a parole violation I was Taken TO Rikers Island C-95 receiving room when I got there I was placed in a cell after Being login TO The Facility I Fell asleep I woke up TO The sound of a lady office saying That She was going TO give out 2 Box of cereal Then That when a male C.O. Step in and Told her That he will Do it. when she walk away he said he was ~~at~~ Only giving out 1 Box he gave me and The other inmates 1 Box I Threw it at The gate Then he walk away and come Back with 5 to 7 officers and one female Capt. I was Told TO Step out The cell. I complied I was escorted TO a Strip Search area ~~at~~ Then I was surrounded By The officers and They had Their Chemical agent in Their had and ordered me TO remove my Clothes I Did as I was Told Because I was in Fear of my life ONE of The officers Told me TO Turn around and place my hands on The wall and Not TO move

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claim(1) I Look around and Seen all The officers Standing with The agents in The hands The officer inserted a condom ~~on~~ as the Female Capt. Look on as he vigorously inserted ~~his~~ penis in to my rectum and This ~~is~~ Time my mind was racing where I lost consciousness. ~~The~~ The last Thing I heard was This is what we Do TO gangsters

claim(2) after The Sexual encounter I was ~~placed~~ placed in To a cell where a capt and a Dept. came To The Door I informed Them of what happened TO me in The search area They Told me That They will look in To it ~~at that~~ 5 minutes after I Talked To Them The officers That Sexually assaulted me was walking out Side The cell looking in, They enter the cell and came after me I ran To The Toilet where it was clogged up and put my hand ~~in~~ and Threw ~~what~~ what was in The Toilet at Them in fear for ~~my~~ my life

at That time They retreated From The cell. Then a extraction Team came I Then put my hands Through and got cuff and was saying I Did What I Did in fear of my life

Claim(3) I was Taken To The clinic where I Seen a Doctor I informed him of what happen To me in The search area he Told me To go Back To my cell and he will Put it in my medical records That when I Told him if he Dont send me to a out Side Hospital its going to Be a situation when he look in my underwear he seen "Blood" Then he Told The Female Capt. he was sending me out she Told him NO send him Back To his cell I Told him ~~that~~ That They are going To have To Kill me

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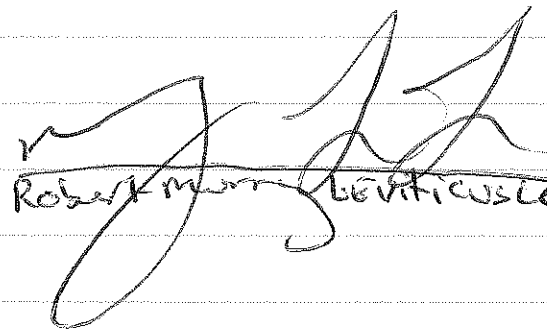
claim(4) after That Dept Foo came and had 2 John Doe officers put cuff on me That was so tight it cut in to my skin when I got to the hospital The cuff was so tight I was crying The hospital staff was asking the officers to loosen the cuff the officers told the hospital staff that they was ordered not to by Dept Foo The Date was Nov 16, 2020

claim(5) when I did see the Rape Specialist She ask me what ~~what~~ happen I told her and I was seen at Bellevue Hospital where a rape kit was administered and according to her There was Evidence That Mr Murray was Rape There was bleeding Through my rectal area and I was in pain for several Days

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claim (b) Then I call Ginger Lope when I got back to the facility she sent a complaint to Doc to preserve the video footage of that area from Nov 14, 2020 during and after so the tape should be preserved of me coming in and going out so they should have the tape from Nov 14, 2020 to Nov 15, 2020 and I was sent out the facility on Nov 16, 2020 to Bellevue Hospital

From: LEviticus Bofmet Lucifer
Slave Name Robert Lee Murray


Robert Murray LEviticus Lucifer

Report of Sexual Assault/Request for Video Preservation: Robert Murray, B&C; 895-20-00730; NYSID: 06093686K, AMKC

Lopez, Ginger <MGLopez@legal-aid.org>

Thu 11/19/2020 2:25 PM

To: 'sarena.townsend@doc.nyc.gov' <sarena.townsend@doc.nyc.gov>; 'Ruben.Benitez@doc.nyc.gov' <Ruben.Benitez@doc.nyc.gov>

Cc: 'Heidi.Grossman@doc.nyc.gov' <Heidi.Grossman@doc.nyc.gov>; 'Brenda.cooke@doc.nyc.gov' <Brenda.cooke@doc.nyc.gov>; 'Tara.Daggett@doc.nyc.gov' <Tara.Daggett@doc.nyc.gov>; 'constituentservices@doc.nyc.gov' <constituentservices@doc.nyc.gov>; 'complaints@doc.nyc.gov' <complaints@doc.nyc.gov>; Anna Friedberg <afriedberg@tillidgroup.com>

I write on behalf of Mr. Robert Murray, 895-20-00730, who reports that he was sexually assaulted by a correction officer on Saturday, November 14th between the hours of 4 and 9A.M., in the AMKC receiving room.

Mr. Murray says before the sexual assault he was having a disagreement with correction officers regarding the distribution of cereal. Mr. Murray says after the disagreement he was then escorted to the receiving room in AMKC and stripped searched. He says then in the presence of a female officer, a male officer put a condom on and told Mr. Murray, "this is what we do to gangsters" and proceeded to sexually assault him.

Mr. Murray says he was taken to Bellevue Hospital where a rape kit was administered and according to Mr. Murray, there was evidence that he had been sexually assaulted. Mr. Murray says he was bleeding through his rectal area and in severe pain for several days.

Mr. Murray says he was interviewed by the Inspector General and provided a statement regarding the sexual assault. Mr. Murray says that there was a camera in the receiving room that captured the assault and he is requesting that the video be preserved for future litigation.

Would you please ensure that all video footage, before, during and after the above reported sexual assault that occurred on Saturday morning, November 14th, in the AMKC receiving room be preserved for possible future litigation?

Please inform me of your actions in response to this request.

Thank you in advance for your attention to this matter.



Mayzabeth Ginger Lopez
Paralegal Casehandler

Prisoners' Rights Project
The Legal Aid Society
199 Water Street 6th Floor
New York, NY 10038

INJURIES:

If you were injured as a result of these actions, describe your injuries and what medical treatment, if any, you required and received.

bleeding Through rectal area and sever pain for several Day The experience was Traumatic and my mind will never Be Right on earth

VI. RELIEF

State briefly what money damages or other relief you want the court to order.

I Lucifer pray once The courts see all The evidence I will receive a just payment, as The court see just and proper

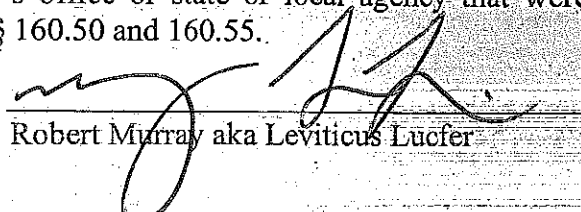
DESIGNATION OF AGENT FOR ACCESS TO SEALED
RECORDS PURSUANT TO NYCPL 160.50 AND 160.55

I, Robert Murray aka Leviticus Lucifer, Date of Birth [REDACTED] SS# [REDACTED]
pursuant to CPL §§ 160.50 and 160.55, hereby designate HON. SYLVIA
O. HINDS-RADIX, Corporation Counsel of the City of New York, or her authorized
representative, as my agent to whom records of the criminal action terminated in my favor
entitled People of the State of New York v. Robert Murray aka Leviticus Lucifer, Docket No. or
Indictment No. _____, in _____ Court, County of _____, State of New
York, relating to my arrest on or about November 14, 2010 may be made available.

I understand that until now the aforesaid records have been sealed pursuant to
CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons
designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom
the records may be made available is not bound by the statutory sealing requirements of CPL
§§ 160.50 and 160.55.

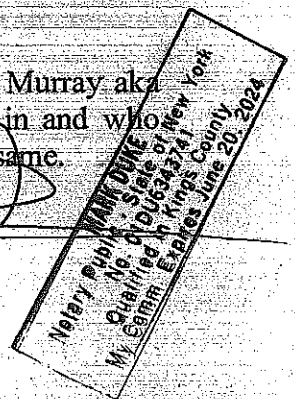
The records to be made available to the person designated above comprise all
records and papers relating to my arrest and prosecution in the criminal action identified herein
on file with any court, police agency, prosecutor's office or state or local agency that were
ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.


Robert Murray aka Leviticus Lucifer

STATE OF NEW YORK)
COUNTY OF Bronx) SS.:

On this 11th day of April, 2023, before me personally came Robert Murray aka
Leviticus Lucifer, to me known and known to me to be the individual described in and who
executed the foregoing instrument, and he acknowledged to me that he executed the same.


NOTARY PUBLIC



To: Felicia Thomas Paralegal
Sent To: The City of
New York
LAW DEPARTMENT
100 CHURCH Street
NEW YORK N.Y. 10007

C.C. SOUTHERN DISTRICT courts



AUTORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

(This form has been approved by the New York State Department of Health)

Patient Name Robert Murray	Date of Birth 72	Social Security Number [REDACTED]
Patient Address 18-18 HAZEN ST EAST ELmhurst NY 11370		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

Bellevue Hospital

8. Name and address of person(s) or category of person to whom this information will be sent:

9. (a). Specific information to be released:

- ☒ Medical Record from (insert date) **2020 NOV** to (insert date) **2023**
- ☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (Indicate by Initialing)

Rm Alcohol/Drug Treatment
Rm Mental Health Information
Rm HIV-Related Information

Authorization to Discuss Health Information

(b) ☒ By initialing here: **Rm** I authorize _____

Initials

Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☐ Other: _____

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law.

Date: **4-10-23**

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.



NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS Robert Murray 18-18 Hazen St East Elmhurst NY 11370		DATE OF BIRTH 72	PATIENT SSN [REDACTED]
		MEDICAL RECORD NUMBER	TELEPHONE NUMBER
NAME OF HEALTH PROVIDER TO RELEASE INFORMATION Bellevue Hospital		SPECIFIC INFORMATION TO BE RELEASED: Information Requested _____ Treatment Dates from <u>NOV 16, 2020</u> to _____	
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT		INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). Please note: unless all of the boxes are checked, we may be unable to process your request. <input type="checkbox"/> Alcohol and/or Substance Abuse Program Information <input type="checkbox"/> Genetic Testing Information <input type="checkbox"/> Mental Health Information <input type="checkbox"/> HIV/AIDS-related Information	
REASON FOR RELEASE OF INFORMATION <input type="checkbox"/> Legal Matter <input type="checkbox"/> Individual's Request <input type="checkbox"/> Other (please specify): _____		WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) <input type="checkbox"/> Event: _____ <input type="checkbox"/> On this date: _____	

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL or SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH, and/or CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

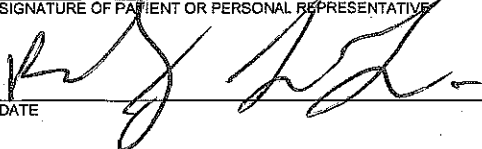
I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE 	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE 4-10-23	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

21 CV 6718

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
_____, 2023


ROBERT MURRAY AKA LEVITICUS
LUCFER

STATE OF NEW YORK)
: SS:
COUNTY OF Bronx)

On the 11th day of April, 2023, before me personally came and appeared ROBERT MURRAY AKA LEVITICUS LUCFER; to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.


NOTARY PUBLIC

MARK DUKE
Notary Public - State of New York
No. 0100834374
Qualified in Kings County
My Comm. Expires June 20, 2024

3-26-202

TO: Hon. Gabriel W. Gorenstein
United States Magistrate Judge
United States District Court

Re: Murray as Leviticus Lucifer v. Dabo et al.
(VEC) (GWG) 22 CV 40216

Slave Name is Robert Lee Murray

Hebrew Name is Leviticus Bor-met Lucifer

This is my Sworn Affidavit under penalty of perjury

Dear Judge Gorenstein:

As True correct, and complete, Not misleading
The truth The whole Truth and nothing
but the truth, documents and on nearly every
single document That the System desires
others To be bound or obligated Such —
means of Signing is an oath or commercial —
Affidavit Executed under penalty of perjury.

"true Correct, and complete"
Whereas in court setting. testimony (oral)
is Stated in judicial terms by being Sworn
to Be "The truth the whole Truth and —
nothing but the Truth so help me" God"

in addition to asserting all matters under Solemn "oath" of personal, Legal liability for the validity of each and every Statement

The DEFENDANTS must provide material evidence to Their Statements

Plaintiff was a patient at Kirby, Forensic Psychiatric Center (Kirby) has video and audio That's where each and every particular assertion to sustain — credibility as it "Stands"

When a person issue an affidavit it is a two edged sword it cut both ways — Someone has to Take "responsibility for writing a lie" "or making a verbal Statement of a lie"

an Affidavit can be Called a True bill and if its a lie You also incur The liability — because This has TO be a Situation — where other people might be adversely affected by it. Things Change when you lie. These Thing affect people lives. people depend on the truth when it comes TO — a Statement made or written under a body of "Law"

Claims made in my Amended Complaint and affidavit if not rebutted with Evidence emerge as The truth of the matter
"He who does deny, admits"

He who fails to assert his rights has "none"

1-Dabo lied in med court Sed I was makeing False allegation against people for Rape and Told med court I was assaulting staff

2- mr Murray is Floridly psychotic and very aggressive at the hospital he has been Smearing and throwing feces in addition to Spitting at and assaulting staff

3- April 27, 2022 Kirby presented["] evidence["] From Dr. Dabo and Dr. Gareen Hamalian TO med court TO give me medication over my objection "give up The evidence"

4- Mr. Murray Screamed loudly in the hallway he shouted that he was being raped while he was observed inserting his fist into his rectum

like I stated in my Affidavit of Point B Y Point Facts Kirby has video and audio

We can stop playing this game The ATTORNEY GENERAL is lying to the court

You told the courts I have not made NO complaints to the mental health institution I DID I got move back to jail before the investigation was over

There are a lot of Base Less allegations But there would have to be some sworn Affidavits by staff at Kirby you stated that I was verbally and "physically" aggressive with staff "physical means assault hands on is physical"

you also told the courts I was spitting on staff "That's a NEW charge"

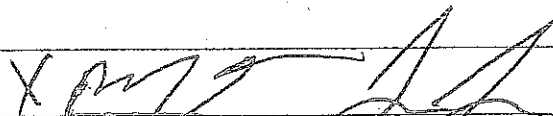
STATEMENT OF Facts

This is my Affidavit of Facts That Led To This Lawsuit With Kirby

NDV 14, 2020 I was Taken To C-95 AMKC receiving room on a parole violation I was Sexual assaulted By officers I commence a Lawsuit 21 CV 6718 in SDNY Defendant's Lawyers Filed a motion To Dismiss I Filed a medical Document with the court and The court ruled in my Favor at The conference I was Told To go To 100 Church St. Corporation Counsel offices To Sign paperwork I was falsely arrested for Thing I Did Not Do By The Police Department They ~~is~~ put cuff on me Take me out Side of 100 - Church St They was going To Kill me I was fighting For my life Not To Be killed By police I Try To get The officers Body camera and video surveillance at 100 Church Street, and at The Bookings at 100 center Street I was set up By Donald J. Trump people I was Sent To Kirby Because I want plea guilty To any of These false charges my charges was dismissed

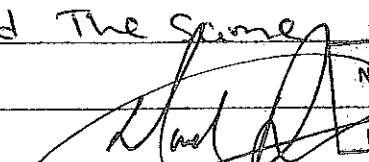
I NOT pleading TO anything Kirby
Tried TO mush my Brain Kirby Dr. DaBo
was giveing me high DOSES OF medication
I Dant Take medications sence 2020
When I Told Them I was NOT Taking
any medication Thats when all The lie's
Started But The Scripture Says every man
is known By his works and what proceeds
from The mouth is what lies in The heart
So The staff members was listening
TO me Talk about Reparations and what
was Stolen From my people. When I was
in The Street I was preaching The
40 acres and a mule and The Atlantic Slave TRADE
and The world Bank's Gold and Silver
and what was Taken out OF Africa when
The Slave TRADE was Takeing place.
people Did NOT want me Talking about That
my life was in Danger it was Two attempts
on my life. TRISH my Freind Take care of
me on earth only her

NO court and no judge can overturn or disregard or abrogate somebody's Affidavit of Truth. The only ONE who has any capacity or right or responsibility or knowledge to rebut my Affidavit of Truth is the ONE who is — adversely affected by it. it's his job, his right his responsibility to speak for himself or make a Statement of Truth with material "EVIDENCE" TO ISSUE his own affidavit under penalty of perjury because no one can speak it for him.


Robert Lee Murray as Leviticus Bofmet Lucher

STATE OF New York)
COUNTY OF ; SS:
)

on this 29th day of March 2023 before me personally came Robert Murray known as Leviticus Bofmet Lucher Executed The foregoing instrument and he acknowledged TO me that he executed The same


NOTARY PUBLIC

MARK DUKE
Notary Public - State of New York
No. 01DU6343741
Qualified in Kings County
My Comm. Expires June 20, 2024

State of New York
Office of the Attorney General
28 Liberty Street
New York, NY 10005

LITIGATION

Copy Sent

VII. PLAINTIFF'S CERTIFICATION AND WARNINGS

By signing below, I certify to the best of my knowledge, information, and belief that: (1) the complaint is not being presented for an improper purpose (such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation); (2) the claims are supported by existing law or by a nonfrivolous argument to change existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Federal Rule of Civil Procedure 11.

I understand that if I file three or more cases while I am a prisoner that are dismissed as frivolous, malicious, or for failure to state a claim, I may be denied *in forma pauperis* status in future cases.

I also understand that prisoners must exhaust administrative procedures before filing an action in federal court about prison conditions, 42 U.S.C. § 1997e(a), and that my case may be dismissed if I have not exhausted administrative remedies as required.

I agree to provide the Clerk's Office with any changes to my address. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Each Plaintiff must sign and date the complaint. Attach additional pages if necessary. If seeking to proceed without prepayment of fees, each plaintiff must also submit an IFP application.

4-10-23
 Dated
 Robert Lee
 First Name Middle Initial
 Plaintiff's Signature
 Murray
 Last Name
 18-18 HAZEN ST
 Prison Address
 Elmhurst NY 11370
 County, City State Zip Code

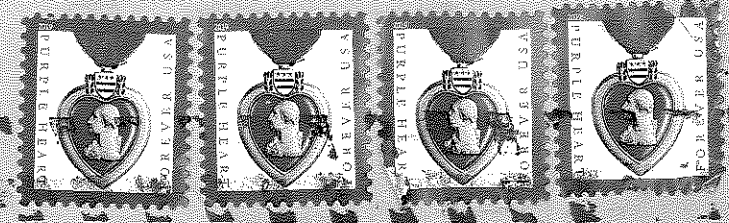
Date on which I am delivering this complaint to prison authorities for mailing:

4-11-23

Robert Murray 950-22-00004

77-158 HARBOR BANK

608 614 620 626 632 638 644



MID ISLAND NY 117

MID ISLAND NY 117

23 7-PM

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2023



APR



10:10 - Se office

UNITED STATE DISTRICT COURT
SOUTHERN DISTRICT OF New York
500 Pearl Street

NEW YORK, NY. 10007

USM P3

Legal mail

